(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(ii) For discharges occurring during any subsequent cost reporting period (or portion thereof) and before October 1, 1994, 50 percent of the amount that the Federal rate determined under paragraph (c)(1) of this section is exceeded by the higher of the following:

(A) The hospital-specific rate as determined under § 412.73.

(B) The hospital-specific rate as determined under § 412.75.

(d) *Additional payments to hospitals experiencing a significant volume decrease.* (1) HCFA provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.

(2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must—

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105).

(i) In determining the adjustment amount, the intermediary considers—

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The intermediary makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

(iii) The intermediary determination is subject to review under subpart R of part 405 of this chapter.

[55 FR 15175, Apr. 20, 1990; 55 FR 32088, Aug. 7, 1990, as amended at 55 FR 36070, Sept. 4, 1990; 57 FR 39824, Sept. 1, 1992; 58 FR 46339, Sept. 1, 1993; 58 FR 67350, Dec. 21, 1993; 59 FR 45400, Sept. 1, 1994]

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

(a) *General rule.* For payment purposes, HCFA treats as a sole community hospital any hospital that is located in a rural area as described in paragraph (b) of this section and that HCFA designates as an EACH under the criteria in paragraph (c) of this section. The payment methodology for sole community hospitals is set forth at § 412.92(d).

(b) *Location in a rural area.* For purposes of this section, a hospital is located in a rural area if it—

(1) Is located outside any area that is a Metropolitan Statistical Area as defined by the Office of Management and Budget or that has been recognized as urban under § 412.62;

(2) Is not deemed to be located in an urban area under § 412.63;

(3) Is not classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board; or

(4) Is not located in a rural county that has been redesignated to an adjacent urban area under § 412.232.

(c) *Criteria for HCFA designation.*

(1) HCFA designates a hospital as an EACH if the hospital is located in a State that has received a grant under section 1820(a)(1) of the Act or in an adjacent State and is designated as an EACH by the State that has received the grant.

(2) HCFA designates a hospital as an EACH if—

(i) The hospital—

(A) Is not eligible for State designation as an EACH solely because the hospital has fewer than 75 inpatient beds and is located 35 miles or less from any other hospital; and

(B) Is located more than 35 miles from the nearest hospital having 75 or more inpatient beds, and is recommended by the State for designation as the EACH member of a proposed network; or

(ii) The following criteria are met—

(A) The hospital seeking EACH designation has entered into a network agreement under § 485.603 of this chapter with a facility that the State has designated as an RPCH, and the hospital designated as an RPCH by the State does not have a network agreement with any existing EACH;

(B) The facility that the State has designated as an RPCH, and that has entered into the network agreement described in paragraph (c)(2)(ii)(A) of this section, is located more than 35 miles from any other hospital having 75 or more inpatient beds;

(C) The distance between the facility that the State has designated as an RPCH and the hospital seeking designation as an EACH is less than the distance between the facility that the State has designated as an RPCH and the nearest hospital that has 75 or more inpatient beds or is designated as an EACH;

(D) The State certifies to HCFA that—

(*1*) The rural health network emergency and medical backup services actually being provided by the hospital seeking EACH designation are essential to the continued existence of the facility as a RPCH; and

(*2*) The existence of the facility as an RPCH is needed to ensure access to health care services in the area of the State served by the RPCH.

For purposes of this paragraph (c)(2)(ii), the location of a hospital will not be considered unless the hospital participates in Medicare under §§ 482.1 through 482.57 of this chapter.

(d) *Criteria for State designation.* A State that has received a grant under section 1820(a)(1) of the Act may designate as an EACH any hospital in the State or in an adjoining State that meets the criteria of this paragraph (d).

(1) *Geographic location.* The hospital meets one of the following requirements:

(i) If it is located in a rural area as described in paragraph (b) of this section, the hospital is located more than 35 miles from any hospital that either has been designated as an EACH, or has been classified as a rural referral center under § 412.96.

(ii) The hospital meets other criteria relating to geographic location, imposed by the State with HCFA's approval.

(2) *Bed capacity and location.* The hospital has at least 75 inpatient beds or is located more than 35 miles from any other hospital.

(3) *Agreements with RPCHs.* The hospital has in effect agreements with the RPCHs that participate in the rural health network (as defined in § 485.603 of this chapter) of which the hospital is a member, to—

(i) Provide emergency and medical backup services to RPCHs participating in the rural health network of which it is a member and throughout its service area;

(ii) Accept patients transferred from an RPCH;

(iii) Receive data from, and transmit data to, the RPCHs; and

(iv) Grant staff privileges to physicians who furnish care at the RPCHs.

(4) *Other requirements.* The hospital meets any other requirements imposed by the State with HCFA's approval.

(e) *Adjustment to the hospital-specific rate for rural EACH's experiencing increased costs.* (1) *General rule.* HCFA increases the applicable hospital-specific rate of an EACH that it treats as a sole community hospital if, during a cost reporting period, the hospital experiences an increase in its Medicare inpatient operating costs per discharge that is directly attributable to activities related to its membership in a rural health network.

(2) *Request and documentation.* In order for a hospital to qualify for an increase in its hospital-specific rate, it must meet the following criteria:

(i) The hospital must submit its request to its intermediary no later than 180 days after the date on the intermediary's notice of program reimbursement.

(ii) The request must include documentation specifically identifying the increased costs resulting from the hospital's participation in a rural health network and show that the increased costs during the cost reporting period will result in increased costs in subsequent cost reporting periods that are not already accounted for under the prospective payment system payment.

(iii) The hospital must show that the cost increases are incremental costs that would not have been incurred in the absence of the hospital's membership in a rural health network.

(iv) The hospital must show that the cost increases do not include amounts for start-up and one-time, nonrecurring costs attributable to its membership in a rural health network.

(3) *Intermediary recommendation.* The intermediary forwards the following material to HCFA within 60 days of receipt from the hospital:

(i) The hospital's documentation and the intermediary's verification of that documentation.

(ii) Its analysis and recommendation of the request.

(iii) The hospital's Medicare cost report for the year in which the increase in costs occurred and the prior year.

(4) *HCFA determination.* HCFA determines, within 120 days of receiving all necessary information from the intermediary, whether an increase in the hospital-specific rate is warranted and, if it is, the amount of the increase. HCFA grants an adjustment only if a hospital's Medicare inpatient operating costs per discharge exceed the hospital's hospital-specific rate. The adjusted hospital-specific rate cannot exceed the hospital's Medicare inpatient operating costs per discharge for the cost reporting period.

(f) *Termination of EACH designation under paragraph (c)(2)(ii)(D).* If HCFA determines that the criteria in paragraph (c)(2)(ii)(D) of this section are no longer met with respect to a hospital HCFA has designated as an EACH under that paragraph, HCFA will terminate the EACH designation of the hospital, effective with discharges occurring on or after 30 days after the date of the determination.

(g) *Review of HCFA Determination.* A determination by HCFA that a hospital does not meet the criteria for EACH designation, or that a hospital's EACH designation should be terminated, is subject to review under part 405, subpart R of this chapter, including the time limits for filing requests for hearings as specified in §§ 405.1811(a) and 405.1841(a)(1) and (b) of this chapter.

[58 FR 30669, May 26, 1993, as amended at 59 FR 45398, Sept. 1, 1994; 60 FR 45848, Sept. 1, 1995; 61 FR 21972, May 13, 1996]

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

§ 412.110 Total Medicare payment.

Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in §§ 412.112 through 412.115, reduced by the amounts specified in § 412.120.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis:

(a) The appropriate prospective payment rate for inpatient operating costs